Complete Summary

GUIDELINE TITLE

Guideline for the diagnosis and management of vitiligo.

BIBLIOGRAPHIC SOURCE(S)

Gawkrodger DJ, Ormerod AD, Shaw L, Mauri-Sole I, Whitton ME, Watts MJ, Anstey AV, Ingham J, Young K, Therapy Guidelines and Audit Subcommittee, British Association of Dermatologists, Clinical Standards Department, Royal College of Physicians of London, Cochrane Skin Group, Vitiligo Society. Guideline for the diagnosis and management of vitiligo. Br J Dermatol 2008 Nov;159(5):1051-76. [125 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Vitiligo

Note: Other depigmenting diseases were considered in the differential diagnosis, but their further management was not included.

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Dermatology
Family Practice
Internal Medicine
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Patients
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To produce a detailed and user-friendly guideline giving the best available clinical advice for the management of vitiligo, based on the best available evidence and expert consensus, taking into account patient choice and clinical expertise

Note: Diagnosis and management for adults and children with any type of vitiligo were considered. Other depigmenting diseases were considered in the differential diagnosis, but their further management was not included.

TARGET POPULATION

Children and adults with vitiligo

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Classical or atypical
2. Blood test to check thyroid function
3. Wood's light to monitor response to therapy
4. Assessment of psychological and quality of life
5. Assessment of disease extent
    - Vitiligo area-scoring index (VASI)
    - Vitiligo European Task Force (VETF)
6. Serial photographs to monitor response

Management/Treatment

1. Explanation of risks and benefits of treatment with patient information
2. Potent topical steroid
3. Camouflaging cosmetics
4. Topical pimecrolimus or tacrolimus
5. Depigmentation with p-(benzyloxy)phenol (MBEH) or 4-methoxyphenol (4MP)

6. Narrowband UVB phototherapy
7. Psoralen with ultraviolet A (PUVA) therapy
8. Close supervision
9. Skin-grafting
10. Autologous epidermal suspension applied to laser-abraded lesions
11. Expanding the autologous cells in tissue culture prior to grafting
12. Transfer of suction blisters
13. Psychological interventions

MAJOR OUTCOMES CONSIDERED

- Accuracy of diagnostic tools and scoring indices
- Quality of life
- Condition progression
- Area reduction/repigmentation
- Treatment complications

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++	High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1–	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	High-quality systematic reviews of case–control or cohort studies High-quality case–control or cohort studies with a very low risk of

	confounding, bias, or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
2-	Case–control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal
3	Nonanalytical studies (e.g., case reports, case series)
4	Expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The development of this guideline was a combined effort involving the Therapy Guidelines and Audit Subcommittee of the British Association of Dermatologists, the Clinical Standards Department of the Royal College of Physicians of London, The Cochrane Skin Group, and the Vitiligo Society.

Nine meetings were held over a period of 12 months. A systematic approach was taken to the development of the guideline, using the method developed by the Scottish Inter-Collegiate Guidelines Network (SIGN; http://www.sign.ac.uk/methodology/index.html). In the initial meetings, the questions to be answered were formulated. Subsequently, literature searches were performed to obtain the evidence, which was subsequently appraised. This appraisal was performed in a standardized way according to the method described by SIGN.

Tables showing the results were produced and are available on the website (http://www.bad.org.uk). The evidence was discussed at meetings of the group where the level of the evidence and the grade of the recommendations were agreed. Where no evidence was available, consensus statements were drawn up. Lastly, the entire guideline was agreed by the Guideline Development Group.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A	At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4 Extrapolated evidence from studies rated as 2+

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) and grades of recommendations (A-D) are presented at the end of the "Major Recommendations" field.

What Symptoms and Signs are Suggestive of Vitiligo?

1. Where vitiligo is classical, as in the symmetrical types, the diagnosis is straightforward and can be made with confidence in primary care. *Grade of recommendation D, Level of evidence 4*
2. In patients with an atypical presentation, diagnosis is more difficult and referral for expert assessment by a dermatologist is recommended. *Grade of recommendation D, Level of evidence 4*

3. In adults with vitiligo, a blood test to check thyroid function should be considered in view of the high prevalence of autoimmune thyroid disease in patients with vitiligo. *Grade of recommendation D, Level of evidence 3*

What is the Accuracy of Wood's light Compared with Naked Eye Examination in the Diagnosis of Vitiligo?

1. Wood's light may be of use in the diagnosis of vitiligo and in the demonstration of the extent and activity of the disease in subjects with skin types I and II. Wood's light can be of use in monitoring response to therapy. *Grade of recommendation D, Level of evidence 4*

What is the Natural History of Vitiligo?

1. The response to treatment of vitiligo should be considered in the context of the natural history, recognizing that spontaneous repigmentation may occur but is uncommon. *Grade of recommendation D, Level of evidence 4*

What is the Quality of Life in Patients with Vitiligo Compared with Other Skin Diseases?

1. Clinicians should make an assessment of the psychological and quality of life (QoL) effects of vitiligo on patients. *Grade of recommendation C, Level of evidence 2+*
2. In therapeutic trials relating to vitiligo, researchers should make the patient's improvement in QoL the most important outcome measure. *Grade of recommendation D, Level of evidence 4*

In All Patients with Vitiligo, What is the Accuracy of a Scoring Index in Showing the Outcome of Common Treatments Compared with Simple Photography?

1. The vitiligo area-scoring index (VASI) and Vitiligo European Task Force (VETF) tools offer a more accurate measure of disease extent than simple clinical photography alone (even when combined with computerized morphometry) and should be used in a research setting. Additionally, the VETF assesses severity and spreading. *Grade of recommendation D, Level of evidence 2+*
2. For routine clinical use, serial photographs should be used to monitor response to treatment in vitiligo. *Grade of recommendation C, Level of evidence 4*

In All patients with Vitiligo, What is the Efficacy of Applying Betamethasone, Clobetasol, Fluocinolone, Fluticasone or Mometasone vs. Placebo or Other Active Treatment in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. In children, and adults with recent onset of vitiligo, treatment with a potent or very potent topical steroid should be considered for a trial period of no more than 2 months. Although benefits have been observed, skin atrophy has been a common side-effect. *Grade of recommendation B (by extrapolation), Level of evidence 1+*

2. In patients with skin types I and II, in the consultation it is appropriate to consider, after discussion with the patient, whether the initial approach may be to use no active treatment other than consideration of the use of camouflage cosmetics, including fake tanning products and the use of sunscreens. *Grade of recommendation D, Level of evidence 4*

In All Patients with Vitiligo, What is the Efficacy of Applying Calcipotriol or Tacalcitol vs. Placebo or an Active Treatment in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. The use of topical calcipotriol as a monotherapy is not recommended. *Grade of recommendation B, Level of evidence 2++*

In All Patients with Vitiligo, What is the Efficacy of Applying Tacrolimus or Pimecrolimus vs. Placebo or an Active Treatment in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. In adults with symmetrical types of vitiligo, topical pimecrolimus should be considered as an alternative to the use of a topical steroid, based on evidence from one study. The side-effect profile of topical pimecrolimus is better than that of a highly potent topical steroid. *Grade of recommendation C, Level of evidence 2+*
2. In children with vitiligo, topical pimecrolimus or tacrolimus should be considered as alternatives to the use of a highly potent topical steroid in view of their better short-term safety profile. *Grade of recommendation B, Level of evidence 1+*

In All Patients with Vitiligo, What is the Efficacy of Applying P-(Benzyloxy)phenol (Monobenzyl Ether of Hydroquinone) vs. Placebo or an Active Treatment in Terms of Reducing Areas of Pigmentation?

1. Depigmentation with p-(benzyloxy)phenol (MBEH) or 4-methoxyphenol (4MP) should be reserved for adults severely affected by vitiligo (e.g., who have more than 50% depigmentation or who have extensive depigmentation on the face or hands) who cannot or choose not to seek repigmentation and who can accept the permanence of never tanning. *Grade of recommendation D, Level of evidence 4*

In All Patients with Vitiligo, What is the Efficacy of a Course of Narrowband Ultraviolet B (UVB) Including High-Intensity Light Sources Compared with Placebo in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. Narrow band ultraviolet B (NB-UVB) phototherapy should be considered for treatment of vitiligo only in children or adults who cannot be adequately managed with more conservative treatments. *Grade of recommendation D, Level of evidence 4*
2. A trial of NB-UVB therapy should be considered for children or adults with widespread vitiligo, or localized vitiligo associated with a significant impact on patient's QoL. Ideally, this treatment should be reserved for patients with darker skin types. *Grade of recommendation D, Level of evidence 3*

3. Before starting treatment, children, their parents and carers, and adults should be made aware that there is no evidence that NB-UVB phototherapy alters the natural history of vitiligo. They should also be made aware that not all patients respond to this treatment, and that some body sites, such as the hands and feet, respond poorly in all patients. They should also be informed of the limit to the number of treatments due to possible side-effects. *Grade of recommendation D, Level of evidence 3*
4. If phototherapy is to be used for treating nonsegmental vitiligo, NB-UVB should be used in preference to oral psoralen with ultraviolet A (PUVA). *Grade of recommendation A, Level of evidence 1+*
5. Evidence is lacking to define an upper limit for the number of treatments with NB-UVB for patients with vitiligo. Taking into account the published data for patients with psoriasis (see below) and in view of the greater susceptibility of vitiliginous skin to sunburn and possible photodamage (due to absence of melanin), it is advised that safety limits for NB-UVB for the treatment of vitiligo are more stringent than those applied to psoriasis, with an arbitrary limit of 200 treatments for skin types I–III. This could be higher for skin types IV–VI at the discretion of the clinician and with the consent of the patient. *Grade of recommendation D, Level of evidence 3*
6. It is recommended that physicians prescribing NB-UVB for vitiligo monitor response closely with the assistance of serial clinical photographs (every 2–3 months), more easily to identify patients who fail to respond adequately or in whom the disease progresses during treatment. *Grade of recommendation D, Level of evidence 3*

In All patients With Vitiligo, What is the Efficacy of a Course of PUVA or PUVA-sol Compared with Placebo in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. PUVA therapy should be considered for treatment of vitiligo only in adults who cannot be adequately managed with more conservative treatments. PUVA is not recommended in children. *Grade of recommendation D, Level of evidence 4*
2. If phototherapy is to be used for treating nonsegmental vitiligo, NB-UVB should usually be used in preference to oral PUVA. *Grade of recommendation A, Level of evidence 1+*
3. A trial of PUVA therapy should be considered only for adults with widespread vitiligo, or localized vitiligo associated with a significant impact on patient's QoL. Ideally, this treatment should be reserved for patients with darker skin types. *Grade of recommendation D, Level of evidence 3*
4. Before starting PUVA treatment patients should be made aware that there is no evidence that this treatment alters the natural history of vitiligo. They should also be made aware that not all patients respond, and that some body sites, such as the hands and feet, respond poorly in all patients. They should also be informed of the limit to the number of treatments due to possible side-effects. *Grade of recommendation D, Level of evidence 3*
5. Evidence is lacking to define an upper limit for the number of treatments with PUVA for patients with vitiligo. Taking into account the published data for patients with psoriasis (see below) and in view of the greater susceptibility of vitiligo skin to psoralen-induced burning and possible photodamage (due to absence of melanin), it is advised that safety limits for PUVA in the treatment of vitiligo are more stringent than those for psoriasis, with an arbitrary limit of

150 treatments for patients with skin types I–III. This could be higher for skin types IV–VI at the discretion of the clinician and with the consent of the patient. *Grade of recommendation D, Level of evidence 3*

6. It is recommended that physicians prescribing PUVA for vitiligo monitor response closely using serial clinical photographs (every 2–3 months) to identify patients who fail to respond adequately or in whom the disease progresses during treatment. *Grade of recommendation D, Level of evidence 3*

In All patients with Vitiligo, What is the Efficacy of a Course of Khellin with Sunlight Ultraviolet A (UVA) or UVB Compared with PUVA or PUVA-sol in Terms of Progression, Area Reduction and Quality of Life Score?

1. There is currently insufficient evidence to recommend khellin with UV in the treatment of vitiligo. *Grade of recommendation D, Level of evidence 3*

Late Complications of PUVA or Narrowband UVB Therapy in Patients with Vitiligo: are Patients Who Have Received Large Doses of PUVA (More than 150 Treatment Sessions) or Narrowband UVB (More than 150 treatment Sessions) at Increased Risk of Developing Premalignant or Malignant Skin Changes?

1. In view of uncertainty regarding the cancer risk, clinicians prescribing NB-UVB or PUVA should be cautious in prescribing these treatments in vitiligo. A clear explanation of the risks and benefits of treatment must be given *before* treatment, with a Patient Information Leaflet written in lay terms. *Grade of recommendation D, Level of evidence 3*
2. Patients treated with PUVA or UVB should have their treatment closely supervised by a consultant dermatologist and the treatment regimen for patients with skin types I–III should not exceed 200 treatments for NB-UVB and 150 treatments for PUVA. This recommendation is based on published evidence for patients with psoriasis. Evidence is lacking to define an upper limit for patients with skin types IV–VI for NB-UVB or PUVA. *Grade of recommendation D, Level of evidence 4*
3. In most patients, NB-UVB should be used in preference to PUVA. *Grade of recommendation A, Level of evidence 1+*

In All Patients with Vitiligo, What is the Efficacy of a Course of Narrowband UVB with a Vitamin D Analogue Compared with Narrowband UVB with Placebo in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. Topical vitamin D analogues in combination with NB-UVB therapy should not be used in the treatment of vitiligo. *Grade of recommendation C, Level of evidence 3*

In All Patients with Vitiligo, What is the Efficacy of a Course of PUVA with a Vitamin D Analogue Compared with PUVA with Placebo in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. Topical vitamin D analogues in combination with PUVA therapy should not be used in the treatment of vitiligo. *Grade of recommendation C, Level of evidence 3*

In All patients with Vitiligo, What is the Efficacy of Systemic (i.e., Orally and Parenterally Administered) Treatments, Including Corticosteroids, Ciclosporin and Other Immunosuppressive Agents, in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. The use of oral dexamethasone to arrest progression of vitiligo cannot be recommended due to an unacceptable risk of side-effects. *Grade of recommendation B, Level of evidence 2++*

In Patients with Vitiligo, What is the Efficacy of a Skin Graft and of Various Forms of Placebo in Terms of Condition Progression, Area Reduction and Quality of Life Score? This May Include Punch Grafts, Full-Thickness Skin Graft, Split-Thickness Skin Graft, Autologous Epidermal Cell Suspension, and Autologous Skin Equivalent (Commercial Skin Equivalent)

1. Surgical treatments in vitiligo should be used only for cosmetically sensitive sites where there have been no new lesions, no Koebner phenomenon and no extension of the lesion in the previous 12 months. *Grade of recommendation A, Level of evidence 1++*
2. Split-skin grafting is the best option when a surgical treatment is required. *Grade of recommendation A, Level of evidence 1+*
3. Minigraft is not recommended due to a high incidence of side-effects and poor cosmetic results including cobblestone appearance and polka dot appearance. *Grade of recommendation A, Level of evidence 1+*
4. Autologous epidermal suspension applied to laser-abraded lesions followed by NB-UVB or PUVA therapy is the optimal surgical transplantation procedure but does require special facilities. *Grade of recommendation A, Level of evidence 1+*
5. Expanding the autologous cells in tissue culture prior to grafting is feasible and treats larger areas successfully, without the need for additional phototherapy. However, the culturing introduces growth factors leading to uncertain risks and cultures can fail, reducing the value of the procedure. *Grade of recommendation D, Level of evidence 3*
6. Transfer of suction blisters is an alternative transplantation method, which shows evidence of benefit over placebo but gives less good coverage than split-skin grafting or laser and cell suspension. *Grade of recommendation B, Level of evidence 1+*

In All Patients with Vitiligo, What is the Efficacy of Cognitive Therapy vs. Psychological Support or No Treatment in Terms of Condition Progression, Area Reduction and Quality of Life Score?

1. Psychological interventions should be offered as a way of improving coping mechanisms in patients with vitiligo. Parents of affected children should be offered psychological counselling. *Grade of recommendation D, Level of evidence 4*

Definitions:

Levels of Evidence

1++	High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1–	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	High-quality systematic reviews of case–control or cohort studies High-quality case–control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
2-	Case–control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal
3	Nonanalytical studies (e.g., case reports, case series)
4	Expert opinion

Grades of Recommendation

A	At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4 Extrapolated evidence from studies rated as 2+

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

Where no evidence was available, consensus statements were drawn up.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of vitiligo

POTENTIAL HARMS

- There are significant potential side-effects, mainly of skin atrophy and hypertrichosis, especially for clobetasol and betamethasone, less so with fluticasone. In children, topical clobetasol induced repigmentation but skin atrophy was a side-effect.
- Stinging is a side effect of pimecrolimus.
- Hydroquinones and related chemicals may cause side-effects. Irritation and occasionally contact dermatitis are recognized, as is the infrequent occurrence of ochronosis. This had led to the banning of hydroquinones from over-the-counter products in Europe. Of more concern is the possibility of carcinogenesis from hydroquinones. However, this is still a matter for debate.
- The risk of skin cancer in patients with vitiligo treated with psoralen with ultraviolet A (PUVA) is currently unclear. There is no long-term follow-up study of the type carried out by Stern and Lange which established the clear cancer risk for PUVA in patients with psoriasis. Despite some authors' claims that high doses of PUVA in vitiligo are safe, it is counterintuitive to believe that patients with vitiligo are at a lower risk of skin cancer with PUVA than patients who have psoriasis. Indeed, the absence of functional melanocytes could put patients with vitiligo at a greater risk. In the absence of persuasive evidence to the contrary, it is logical to recommend more stringent limits on PUVA for vitiligo than apply for psoriasis.
- In one study, side-effects of oral dexamethasone were common, being seen in 20 of 29 subjects, and included weight gain, acne, menstrual irregularity and hypertrichosis.
- Minigrafting had the highest rates of adverse effects, with poor colour match in < 10%, cobblestone appearance in 27%, milia in 13%, partial take in 11% and thick margins in 5%.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Gawkrodger DJ, Ormerod AD, Shaw L, Mauri-Sole I, Whitton ME, Watts MJ, Anstey AV, Ingham J, Young K, Therapy Guidelines and Audit Subcommittee, British Association of Dermatologists, Clinical Standards Department, Royal College of Physicians of London, Cochrane Skin Group, Vitiligo Society. Guideline for the diagnosis and management of vitiligo. Br J Dermatol 2008 Nov;159(5):1051-76. [125 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Nov

GUIDELINE DEVELOPER(S)

British Association of Dermatologists - Medical Specialty Society

SOURCE(S) OF FUNDING

British Association of Dermatologists

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

No member of the Guideline Development Group has declared any interest in companies whose products are named in the guideline, or has had any sponsorship or consultancy from or with companies whose products are named in the guideline, or has had any editorial fees related to commissioned articles for publications named in the guideline, or has a patent pending or existing related to products named in the guideline. D.J.G. has been chairman of the Vitiligo Society's Medical Advisory Board, and M.E.W. is a patron of the Vitiligo Society.

D.J.G., A.D.O., L.S., I.M.-S., M.E.W., M.J.W. and A.V.A. are members of the Guideline Development Group, and technical support was provided by J.I. and K.Y.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on June 4, 2009. The information was verified by the guideline developer on June 18, 2009.

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